Barnett Wood Infant School

Administration of Medicines and Managing Allergies Policy

Barnett Wood Infant School
213, Barnett Wood Lane,
Ashtead KT21 2DF

Barnett Wood Infant School

Policy Impact Statement and Updates

Policy:	Administration of Medicines and Managing Allergies Policy
Date of review:	May 2025
Governor/s responsible:	Non-statutory - approval delegated to Headteacher
Status / date of next review:	Biennial - May 2027
How well has the policy achieved its purpose and outcomes?	
The policy achieves its intended outcomes: • To protect the health and well-being of pupils by ensuring that any necessary medications are administered safely and effectively. • To comply with relevant legislation and guidelines regarding the administration of medicines and the management of allergies in educational settings. • To establish clear procedures for staff regarding the administration of medicines, including prescription and non-prescription medications, and the management of allergic reactions. • To ensure effective communication between parents, healthcare providers, and school staff regarding pupils' medical needs. • To provide training for staff on recognising and responding to allergic reactions and the proper administration of medications.	
Updates and/ or changes to policy:	
May 2025	Updated Healthcare Plan Form

We have carefully considered and analysed the impact of this policy on equality and the possible implications for pupils and or staff with protected characteristics, as part of our commitment to meet the Public Sector Equality Duty (PSED) requirement to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations.

Barnett Wood Infant School

Administration of Medicines and Managing Allergies Policy

1. Introduction

At Barnett Wood we have a shared vision that all children and young people should be healthy, safe, enjoy and achieve. This policy aims to improve and safeguard the lives ofchildren and young people especially those with medical needs and allergies.

There is no legal duty that requires school or setting staff to administer medicines. However, DCSF advise that, 'Schools should ensure that they have sufficient members of support staff who are appropriately trained to manage medicines as part of their duties'. AtBarnett Wood we follow this advice and ensure our two office staff attend regular training. Because we are committed to making sure children stay healthy and attend school regularly, we are prepared to administer medicines to our best abilities. We will store medicines safelyand rely on parents to ensure that medication is kept up to date. We will endeavour to inform parents when prescription medication is coming to its final date and request replacements. If at any time we feel the administration of medicines requirements are beyond our capabilities, or we do not receive up to date medication or acceptable instructions from parents, we will not administer the medicine. In these circumstances we will check with the Headteacher who may take responsibility for administering the medication. We may ask for further support from the school nurse, doctor or the Health Authority.

Our office staff, Headteacher and Senior teachers have this responsibility as part of theirduties and receive regular, appropriate training for this role. Where parents' expectations appear unreasonable or difficult to deal with, the Headteacher will seek advice from the school nurse, or doctor, the child's GP or other medical advisers.

We will:

- Make sure we do everything possible to keep children safe and healthy
- Regularly review our current policies and procedures involving children with medicaland dietary needs – annual review or following any incidents
- Ensure that everyone, including parents, are clear about their respective roles – when requesting administration of medicines or reporting allergies
- Put in place effective management systems to help support individual children withmedical needs – medication request sheet, personal medical plans
- Make sure that medicines are handled responsibly and stored safely
- Ensure that all school staff are clear about what to do in the event of a medical emergency by providing regular training for staff
- Record administering of medicines that takes place with dosage, time and by whom
- Set alarms to remind us of the times to administer medicines following requests

2. Disability Discrimination Act (DDA) 1995.

We will consider making reasonable adjustments for disabled children including those withmedical needs at different levels of school life. This may include alteration to the physical environment (disability action plan). Staff may need to take extra care in supervising someactivities to make sure that these children, and others, are not put at risk.

Schools are under a duty to plan strategically to increase access. We will always forward plan in anticipation of the admission of a disabled pupil with medical needs so that they canaccess the school premises, the curriculum and the provision of resources to ensure accessibility. We will consider medical needs of our present and prospective pupils and ensure training takes place to support these children (e.g. staff receive regular updates on Epipen administration and first aid).

3. Supporting children with medical and dietary needs

We will ask parents to provide us with information about their child's medical condition ordietary needs. Our induction form requests that parents share any special Educational or Medical needs in order that we can prepare appropriately for their child.

We may also request information or details from the General Practitioner (GP) or paediatrician, school nurse or a health visitor. We work with parents to produce a personalmedical plan for individuals who need this sort of support.

4. Procedures for managing prescription medicines

In this section we cover general procedures. We have a step by step procedure for administrating medicines in the front cover of the medical file, main office.

Parents are asked to give written agreement for any medicines to be given to their child.The school has a parent request form which is robust in its information gathering and recording of administration. These are kept in the medical folder, dated and signed.

Children may not keep medicines with them, however we will make sure that any child whohas severe anaphylactic responses to certain foods will have medication both in the classroom and a spare set in the office. This also goes out with the child at lunchtime – lunchtime supervisors are responsible for the bum bags containing emergency medication.Medicines must be stored in the school office. The medicine may not be returned to the child at the end of the day. It must be collected by the adult responsible for the child.

We will not accept prescription medicines that have been taken out of the container as originally dispensed nor make changes to dosages that appear on the prescription container.If necessary, we will check with GP or school nurse.

5. ALLERGENS AND ADRENALINE PEN ADMINISTRATION

Some children in the school may require Epipen administration. The prescribed Epipen is kept in a bag in the child's classroom. The bag may be carried by the child as he/she moves to different areas of the school. This is important as the child moves to lunch times as thisposes the most risk. A lunchtime supervisor is nominated to be responsible for each child's bag. Staff receive training in both taking responsibility for the bag and administering the pen if needed whilst following the Emergency procedure.

6. Procedures for managing prescription medicines on trips and outings

The office staff will prepare a medical bag and medical information sheet for the teacher incharge of any school trips. The office staff will make sure they report verbally to the teacher in charge covering all individual medical needs.

The teacher in charge will administer medicines and report administration of these to theoffice staff on their return.

7. Non - prescribed medicines

Staff should **never** give a non-prescribed medicine to a child unless there is specific prior written permission from the parents. The Headteacher or teacher in charge must agree to administer a non-prescribed medicine. (A child may develop a high temperature, headache ortooth ache and parent may request that we administer Calpol in the child's best interest).

Our medical cupboard has a small supply of Calpol for such instances and pain relief for adult staff (paracetamol). Staff may take this at their own request.

8. **Safe storage of medicines – these are kept in a secure place in main office area**

Medicines will be kept strictly in accordance with product instructions (paying particular note to temperature) and in the original container in which dispensed. Medicines are kept outof reach of children in the top cupboard in office area or locked in the fridge if temperature control is required.

Office staff will make sure all medicines are labelled with child's name and clear dosageinstructions and frequency of administration. These are also confirmed with parents.

Any discrepancies must be resolved with parents, GP or school nurse and these must berecorded in medical request form.

9. Storing Medicines

All emergency medicines, such as asthma inhalers and adrenaline pens, should be readily available to adults who will administer the medication. At Barnett Wood we will look after allmedication in the school office and a second dose of the same medication for those with epipens, will be kept in the child's classroom and move with him/her at certain times of the day (lunchtimes, party times).

10. Sports Activities

In some circumstances staff may need to consider a risk assessment for individuals or groups of children. We have assessed the risk of all our children who may require their inhaler and followed advice from school nurse. Inhalers are all kept in the office and administered by office staff when required. All teaching staff and lunch staff are aware ofchildren who may need inhalers and will send a request to the office for child's inhaler.

Children with epipens also have an inhaler in their personal medical bags.

A first aid box is available during each lunch break with a designated member of staff to deal with minor injuries. A first aid box is also available at the swimming pool and our After-School Club facility in The Beehive.

11. Emergency Procedures

After assessing a child's or adult's condition, the emergency services may need to becalled.
As soon as the decision is made to call the emergency services the following procedure willtake place:

1. A member of staff will declare themselves 'in charge of the situation' – Headteacher,office staff, senior teacher or the first person to asses the emergency.
2. Adult in charge will direct members of staff/adults to –
   - call ambulance,
   - collect child's information card
   - inform parents
   - move any children to safety (or away from incident)
   - open gate and wait to direct ambulance
   - be ready to meet parent/s
   - KEEP A RECORD OF INCIDENT AND ANY MEDICINE GIVEN AND GIVE THIS TOEMERGENCY STAFF

3. A member of staff should always accompany a child taken to hospital by ambulance if parent is not available, and should stay until the parent arrives. Health professionals areresponsible for any decisions on medical treatment when parents are not available.

4. In an emergency situation, staff should never take children to hospital in their own car;it is safer to call an ambulance.

12. Long Term Medical needs

Any long term medical needs will require a medical plan which will be written by the child's consultant or the headteacher with guidance from the parents and medical advisers. The plan will include symptoms and instructions. These plans will be brought to the attention ofall staff including lunch time supervisors. The plans will be reviewed regularly with parents.

13. Confidentiality

The headteacher and staff should always treat medical information confidentially. The headteacher should agree with the child where appropriate, or otherwise the parent, who else should have access to records and other information about a child. In most cases it is inthe child's interest for all adults in school to know their needs.

Appendix 1

COMMON CONDITIONS – the following pages give information about the most commonconditions taken from DCSF information guidance on Administering of Medicines.

PRACTICAL ADVICE ON ASTHMA, EPILEPSY, DIABETES AND ANAPHYLAXISINTRODUCTION

The medical conditions in children that most commonly cause concern in schools and settingsare asthma, diabetes, epilepsy and severe allergic reaction (anaphylaxis). This section provides some basic information about these conditions but it is important that the needs ofchildren are assessed on an individual basis.

ASTHMA - NB THE SCHOOL HAS A SPARE ASTHMA DEVICE IF NECESSARY

What is Asthma?

- Asthma is common and appears to be increasingly prevalent in children and youngpeople. One in ten children have asthma in the UK.

- The most common symptoms of asthma are coughing, wheezing or whistling noise inthe chest, tight feelings in the chest or getting short of breath. Younger children may verbalise this by saying that their tummy hurts or that it feels like someone issitting on their chest. Not everyone will get all these symptoms, and some childrenmay only get symptoms from time to time.

- However in early years settings staff may not be able to rely on younger children being able to identify or verbalise when their symptoms are getting worse, or what medicines they should take and when. It is therefore imperative that early years andprimary school staff, who have younger children in their classes, know how to identifywhen symptoms are getting worse and what to do for children with asthma when this happens. This should be supported by written asthma plans, asthma school cards provided by parents, and regular training and support for staff. Children with significant asthma should have an individual health care plan.

Medicine and Control

- There are two main types of medicines used to treat asthma, relievers and preventers. Usually a child will only need a reliever during the school day. **Relievers** (blue inhalers) are medicines taken immediately to relieve asthma symptoms and are taken during an asthma attack. They are sometimes taken before exercise**.** Whilst**Preventers** (brown, red, orange inhalers, sometimes tablets) are usually used out of school hours.

- **Children with asthma need to have immediate access to their reliever inhalers when they need them.** Inhaler devices usually deliver asthma medicines. A spacer device is used with most inhalers, and the child may need some help to do this. It is good practice to support children with asthma to take charge of and use their inhalerfrom an early age, and many do.

- Children who are able to use their inhalers themselves should be allowed to carry them with them. If the child is too young or immature to take personal responsibilityfor their inhaler, staff should make sure that it is stored in a safe but readily
accessible place, and clearly marked with the child's name. Inhalers should always beavailable during physical education, sports activities and educational visits.

- For a child with severe asthma, the health care professional may prescribe a spareinhaler to be kept in the school or setting.

- The signs of an asthma attack include:

  - coughing
  - being short of breath
  - wheezy breathing
  - feeling of tight chest
  - being unusually quiet

- When a child has an attack, they should be treated according to their individualhealth care plan. An ambulance should be called if:

  - the symptoms do not improve sufficiently in 5-10 minutes
  - the child is too breathless to speak
  - the child is becoming exhausted
  - the child looks blue

- It is important to agree with parents of children with asthma how to recognise whentheir child's asthma gets worse and what action will be taken. (At Barnett Wood we have an asthma school card which we ask parents to fill in if they have asthma).

- A child should have a regular asthma review with their GP or other relevant healthcare professional. Parents should arrange the review and make sure that a copyof their child's management plan is available to the school or setting. Children should have a reliever inhaler with them when they are in school or in a setting.

- Children with asthma should participate in all aspects of the school or setting 'day' including physical activities. They need to take their reliever inhaler with them on alloff-site activities. Physical activity benefits children with asthma in the same way asother children. Swimming is particularly beneficial, although endurance work should be avoided. Some children may need to take their reliever asthma medicines before any physical exertion. Warm-up activities are essential before any sudden activity especially in cold weather. Particular care may be necessary in cold or wet weather.

- Reluctance to participate in physical activities should be discussed with parents, staff and the child. However children with asthma should not be forced to take partif they feel unwell. Children should be encouraged to recognise when their symptomsinhibit their ability to participate.

- Children with asthma may not attend on some days due to their condition, and may also at times have some sleep disturbances due to night symptoms. This may affecttheir concentration. Such issues should be discussed with the child's parents or attendance officers as appropriate.

- Barnett Wood uses the asthma.org.uk website or call number - **0300 222 5800 whenrequiring help or support**. We consider the school environment, by removing as many potential triggers for children with asthma as possible.

- All staff have updated training provided by professionals with information about asthma including recognising worsening symptoms of asthma, knowing about asthmamedicines and their delivery and what to do if a child has an asthma attack.

EPILEPSY and Diabetes are not covered in medical training and at present we do nothave any children diagnosed with either of these conditions but we have downloaded information.

What is Epilepsy?

- Children with epilepsy have repeated seizures that start in the brain. An epileptic seizure, sometimes called a fit, turn or blackout can happen to anyone at any time. Seizures can happen for many reasons. At least one in 200 children have epilepsy andaround 80 per cent of them attend mainstream school. Most children with diagnosed epilepsy never have a seizure during the school day. Epilepsy is a very individual condition.

- Seizures can take many different forms and a wide range of terms may be used to describe the particular seizure pattern that individual children experience. Parents and health care professionals should provide information to schools, to be incorporated into the individual health care plan, setting out the particular pattern ofan individual child's epilepsy. If a child does experience a seizure in a school or setting, details should be recorded and communicated to parents including:

  - any factors which might possibly have acted as a trigger to the seizure – e.g.visual/auditory stimulation, emotion (anxiety, upset)
  - any unusual "feelings" reported by the child prior to the seizure
  - parts of the body demonstrating seizure activity e.g. limbs or facial muscles
  - the timing of the seizure – when it happened and how long it lasted
  - whether the child lost consciousness
  - whether the child was incontinent

This will help parents to give more accurate information on seizures and seizure frequencyto the child's specialist.

- What the child experiences depends whether all or which part of the brain is affected. Not all seizures involve loss of consciousness. When only a part of the brainis affected, a child will remain conscious with symptoms ranging from the twitching orjerking of a limb to experiencing strange tastes or sensations such as pins and needles. Where consciousness is affected; a child may appear confused, wander around and be unaware of their surroundings. They could also behave in unusual ways such as plucking at clothes, fiddling with objects or making mumbling sounds and chewing movements. They may not respond if spoken to. Afterwards, they may have little or no memory of the seizure.

- In some cases, such seizures go on to affect all of the brain and the child loses consciousness. Such seizures might start with the child crying out, then the musclesbecoming stiff and rigid. The child may fall down. Then there are jerking movementsas muscles relax and tighten rhythmically. During a seizure breathing may become difficult and the child's colour may change to a pale blue or grey colour around the mouth. Some children may bite their tongue or cheek and may wet themselves.

- After a seizure a child may feel tired, be confused, have a headache and need time torest or sleep. Recovery times vary. Some children feel better after a few minutes while others may need to sleep for several hours.

- Another type of seizure affecting all of the brain involves a loss of consciousness fora few seconds. A child may appear 'blank' or 'staring', sometimes with fluttering of theeyelids. Such absence seizures can be so subtle that they may go unnoticed. They might be mistaken for daydreaming or not paying attention in class. If such seizures happen frequently they could be a cause of deteriorating academic performance.

Medicine and Control

- Most children with epilepsy take anti-epileptic medicines to stop or reduce theirseizures. Regular medicine should not need to be given during school hours.

- Triggers such as anxiety, stress, tiredness or being unwell may increase a child's chance of having a seizure. Flashing or flickering lights and some geometric shapes orpatterns can also trigger seizures. This is called photosensitivity. It is very rare. Most children with epilepsy can use computers and watch television without any problem.

- Children with epilepsy should be included in all activities. Extra care may be needed insome areas such as swimming or working in science laboratories. Concerns about safety should be discussed with the child and parents as part of the health care plan.

During a seizure it is important to make sure the child is in a safe position, not to restrict achild's movements and to allow the seizure to take its course. In a convulsive seizure puttingsomething soft under the child's head will help to protect it. Nothing should be placed in their mouth. After a convulsive seizure has stopped, the child should be placed in the recovery position and stayed with, until they are fully recovered.

- An ambulance should be called during a convulsive seizure if:

• it is the child's first seizure • the child has injured themselves badly • they have problems breathing after a seizure • a seizure lasts longer than the period set out in the child's health care plan • a seizure lasts for five minutes if you do not know how long they usually last for that child • there are repeated seizures, unless this is usual for the child as set out in the child's health care plan

- Such information should be an integral part of the school or setting's emergency procedures as discussed at paragraphs 115 - 117 but also relate specifically to thechild's individual health care plan. The health care plan should clearly identify thetype or types of seizures, including seizure descriptions, possible triggers and whether emergency intervention may be required.

- Most seizures last for a few seconds or minutes, and stop of their own accord. Some children who have longer seizures may be prescribed diazepam for rectal administration. This is an effective emergency treatment for prolonged seizures. Theepilepsy nurse or a paediatrician should provide guidance as to when to administer it and why.

- Training in the administration of rectal diazepam is needed and will be available fromlocal health services. Staying with the child afterwards is important as diazepam maycause drowsiness. Where it is considered clinically appropriate, a liquid solution midazolam, given into the mouth or intra-nasally, may be prescribed as an alternative to rectal Diazepam. Instructions for use **must** come from the prescribing doctor. Formore information on administration of rectal diazepam, see Form 9.

- Children and young people requiring rectal diazepam will vary in age, background and ethnicity, and will have differing levels of need, ability and communication skills. If arrangements can be made for two adults, at least one of the same gender as the child, to be present for such treatment, this minimises the potential for accusationsof abuse. Two adults can also often ease practical administration of treatment. Staff should protect the dignity of the child as far as possible, even in emergencies.The criteria under the national standards for under 8s day care requires the registered person to ensure the privacy of children when intimate care is being provided.

DIABETES

What is Diabetes?

- Diabetes is a condition where the level of glucose in the blood rises. This is either due to the lack of insulin (Type 1 diabetes) or because there is insufficient insulin forthe child's needs or the insulin is not working properly (Type 2 diabetes).

- About one in 550 school-age children have diabetes. The majority of children have Type 1 diabetes. They normally need to have daily insulin injections, to monitor theirblood glucose level and to eat regularly according to their personal dietary plan. Children with Type 2 diabetes are usually treated by diet and exercise alone.

- Each child may experience different symptoms and this should be discussed whendrawing up the health care plan. Greater than usual need to go to the toilet or to drink, tiredness and weight loss may indicate poor diabetic control, and staff will naturally wish to draw any such signs to the parents' attention.

Medicine and Control

- The diabetes of the majority of children is controlled by injections of insulin each day. Most younger children will be on a twice a day insulin regime of a longer acting insulin and it is unlikely that these will need to be given during school hours, although for those who do it may be necessary for an adult to administer the injection. Older children may be on multiple injections and others may be controlledon an insulin pump. Most children can manage their own injections, but if doses are required at school supervision may be required, and also a suitable, private place to carry it out.

- Increasingly, older children are taught to count their carbohydrate intake and adjust their insulin accordingly. This means that they have a daily dose of long- acting insulin at home, usually at bedtime; and then insulin with breakfast, lunch andthe evening meal, and before substantial snacks. The child is taught how much insulin to give with each meal, depending on the amount of carbohydrate eaten. They may or may not need to test blood sugar prior to the meal and to decide how much insulin to give. Diabetic specialists would only implement this type of regime when they were confident that the child was competent. The child is then responsible for the injections and the regime would be set out in the individual health care plan.

- Children with diabetes need to ensure that their blood glucose levels remain stable and may check their levels by taking a small sample of blood and using a small monitor at regular intervals. They may need to do this during the school lunch break, before PE or more regularly if their insulin needs adjusting. Most older children will be able to do this themselves and will simply need a suitable place to doso. However younger children may need adult supervision to carry out the test and/or interpret test results.

- When staff agree to administer blood glucose tests or insulin injections, theyshould be trained by an appropriate health professional.

- Children with diabetes need to be allowed to eat regularly during the day. This mayinclude eating snacks during class-time or prior to exercise. Schools may need to make special arrangements for pupils with diabetes if the school has staggered lunchtimes. If a meal or snack is missed, or after strenuous activity, the child may experience a hypoglycaemic episode (a hypo) during which blood glucose level fall

too low. Staff in charge of physical education or other physical activity sessions should be aware of the need for children with diabetes to have glucose tablets or asugary drink to hand.

- Staff should be aware that the following symptoms, either individually or combined,may be indicators of low blood sugar - a **hypoglycaemic reaction** (hypo) in a child with diabetes:

  - hunger
  - sweating
  - drowsiness
  - pallor
  - glazed eyes
  - shaking or trembling
  - lack of concentration
  - irritability
  - headache
  - mood changes, especially angry or aggressive behaviour

- Each child may experience different symptoms and this should be discussed whendrawing up a health care plan.

- If a child has a hypo, it is very important that the child is not left alone and that afast acting sugar, such as glucose tablets, a glucose rich gel, or a sugary drink is brought to the child and given immediately. Slower acting starchy food, such as a sandwich or two biscuits and a glass of milk, should be given once the child has recovered, some 10-15 minutes later.

An ambulance should be called if:

- the child's recovery takes longer than 10-15minutes
- the child becomes unconscious

- Some children may experience **hyperglycaemia** (high glucose level) and have a greater than usual need to go to the toilet or to drink. Tiredness and weight lossmay indicate poor diabetic control, and staff will naturally wish to draw any such signs to the parents' attention. If the child is unwell, vomiting or has diarrhoea thiscan lead to dehydration. If the child is giving off a smell of pear drops or acetone this may be a sign of ketosis and dehydration and the child will need urgent medicalattention.

- Such information should be an integral part of the school or setting's emergency procedures as discussed at paragraphs 115 – 117 but also relate specifically to thechild's individual health care plan.

ANAPHYLAXIS

What is anaphylaxis?

- Anaphylaxis is an acute, severe allergic reaction requiring immediate medical attention. It usually occurs within seconds or minutes of exposure to a certain foodor substance, but on rare occasions may happen after a few hours.

- Common triggers include peanuts, tree nuts, sesame, eggs, cow's milk, fish, certainfruits such as kiwifruit, and also penicillin, latex and the venom of stinging insects(such as bees, wasps or hornets).

- The most severe form of allergic reaction is anaphylactic shock, when the blood pressure falls dramatically and the patient loses consciousness. Fortunately, this israre among young children below teenage years. More commonly among children there may be swelling in the throat, which can restrict the air supply, or severe asthma. Any symptoms affecting the breathing are serious.

- Less severe symptoms may include tingling or itching in the mouth, hives anywhere on thebody, generalised flushing of the skin or abdominal cramps, nausea and vomiting. Even where mild symptoms are present, the child should be watched carefully. They may be heralding the start of a more serious reaction.

Medicine and Control

- The treatment for a severe allergic reaction is an injection of adrenaline (also known as epinephrine). Pre-loaded injection devices containing one measured dose of adrenaline areavailable on prescription. The devices are available in two strengths – adult and junior.

- Should a severe allergic reaction occur, the adrenaline injection should be administeredinto the muscle of the upper outer thigh. **An ambulance should always be called.**

- Staff that volunteer to be trained in the use of these devices can be reassured thatthey are simple to administer. Adrenaline injectors, given in accordance with the manufacturer's instructions, are a well-understood and safe delivery mechanism. It is notpossible to give too large a dose using this device. The needle is not seen until after it has been withdrawn from the child's leg. In cases of doubt it is better to give the injection than to hold back.

- The decision on how many adrenaline devices the school or setting should hold, and whereto store them, has to be decided on an individual basis between the head, the child's parents and medical staff involved. Barnett Wood asks for two devices to be kept in school. One in class and one in the office.

- Where children are considered to be sufficiently responsible to carry their emergencytreatment on their person[1], there should always be a spare set kept safely which is notlocked away and is accessible to all staff. In large schools or split sites, it is often quicker for staff to use an injector that is with the child rather than taking time to collect one from a central location.

- Studies have shown that the risks for allergic children are reduced where an individual health care plan is in place. Reactions become rarer and when they occur they are mostlymild. The plan will need to be agreed by the child's parents, the school and the treating doctor.

- Important issues specific to anaphylaxis to be covered include:

  - anaphylaxis – what may trigger it
  - what to do in an emergency
  - prescribed medicine
  - food management
  - precautionary measures

- Once staff have agreed to administer medicine to an allergic child in an emergency, a training session will need to be provided by local health services. Staff should have theopportunity to practise with trainer injection devices.

- Day to day policy measures are needed for food management, awareness of the child's needs in relation to the menu, individual meal requirements and snacks in school. When kitchen staff are employed by a separate organisation, it is important to ensure that thecatering supervisor is fully aware of the child's particular requirements. A 'kitchen code of practice' is in place at Barnett Wood as follows:

BARNETT WOOD INFANT SCHOOL
KITCHEN CODE OF PRACTICE

1. **Parents return dietary request forms to caterers TwelveFifteen. Forms are available to view in kitchen file**
2. **By 10.00am each day, office staff inform catering service of childrenrequiring dietary adjustments.**
3. **Catering service provide meal along with written menu information for children requiring dietary adjustments.**
4. **Serving staff write individual requirements on lunch notice board. Barnett Wood Lunch Supervisors check list and check correct lunch foreach child with dietary needs. IF IN DOUBT, ASK AND CHECK. Children have named plates for main course and dessert.**
5. **ANY ERRORS MUST BE REPORTED TO THE HEADTEACHER.**

- Parents often ask for the headteacher to exclude from the premises, the food to whichtheir child is allergic. This is not always feasible, although appropriate steps to minimiseany risks to allergic children will be taken.

- Children who are at risk of severe allergic reactions are not ill in the usual sense. They

are normal children in every respect – except that if they come into contact with a certain food or substance, they may become very unwell. It is important that these children are not stigmatised or made to feel different. It is important, too, to allayparents' fears by reassuring them that prompt and efficient action will be taken inaccordance with medical advice and guidance.

Anaphylaxis is manageable. With sound precautionary measures and support from the staff,school life may continue as normal for all concerned.

FORM 1 - Contacting Emergency Services

Request for an Ambulance

Dial 999, ask for ambulance and be ready with the following information

1. Your telephone number

2. Give your location as follows:

   Barnett Wood Infant School, Barnett Wood Lane, Ashtead, Surrey

3. State that the postcode is KT21 2DF

4. Give exact location in the school/setting (insert brief description)

5. Give your name

6. Give name of child and a brief description of child's symptoms

7. Inform Ambulance Control of the best entrance to use (usually thevehicle gate) and state that the crew will be met and taken to (insert place/area of school)

Speak clearly and slowly and be ready to repeat information if asked.

Put a completed copy of this form by the telephone**.**

Barnett Wood Infant School
Healthcare Plan

Name of School/Setting	**Barnett Wood Infant School**
Child's name	
Date of Birth	
Year Group/Class	
Child's Address	
Medical Diagnosis or Condition	
Date	
Review date	

CONTACT INFORMATION

Family contact 1

Name	
Phone No. (work)	
Phone No. (home)	
Phone No. (mobile)	

Family contact 2

Name	
Phone No. (work)	
Phone No. (home)	
Phone No. (mobile)	

Clinic/Hospital contact

Name _____

Phone No. _____

GP

Name _____

Phone No. _____

Describe medical needs and give details of child's symptoms:

Daily care requirements: (e.g. before sport/at lunchtime)

Describe what constitutes an emergency for the child, and the action to take if this occurs:

Follow up care:

Who is responsible in an Emergency: (State if different for off-site activities)

Form copied to: